98th Congress
2d Session

COMMITTEE PRINT

S. PRT.
98-211

LONG-TERM CARE IN WESTERN EUROPE AND CANADA: IMPLICATIONS FOR THE UNITED STATES

AN INFORMATION PAPER

PREPARED FOR USE BY THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

JULY 1984

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U.S. GOVERNMENT PRINTING OFFICE

34-708 O WASHINGTON : 1984

For sale by the Superintendent of Documents, U.S. Government Printing Office
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S142-6

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PREFACE

Long-term care is now one of the principal challenges for policymakers concerned about the needs of older Americans. Although medicare and medicaid spend billions of dollars each year for postacute care, the long-term care services needed by older Americans and their families are too often either unavailable or unaffordable.

Congressional efforts to improve the overall delivery of long-term care include such experimental programs as the channeling projects, the medicaid home and community-based waivers, and the social health maintenance organizations. While these demonstrations show great promise, we may also learn from the experiences of our neighbor, Canada, and our friends in Western Europe, who are 40 years ahead of us in the proportion of elderly persons in their populations.

The Senate Special Committee on Aging asked Project HOPE to undertake a comparison of long-term care systems. The Project HOPE's Center for Health Affairs, a division of the international medical organization, provides research and policy analysis on health issues.

This paper looks at the ways in which Canada and Western European countries meet the needs of the frail elderly population. Specifically, the paper compares demographic trends, the amount of public funds spent per elderly person, and the relative distribution and use of services—to assess their implications for U.S. policy. While none of the countries included in this study have ideal long-term care systems in place, their collective experiences are nonetheless instructive.

Most notably, the basic similarities of the compared long-term care systems are more striking than the differences. In all of the countries, for example, the range of services is virtually identical. Much like the United States, each of the countries identified problems with: (1) the coordination of all services; (2) the integration of medical and social services; and (3) the design of the programs to target those most in need of care. In each of these countries, long-term care reforms have been incremental rather than fundamental. In each case, the supply of new or more services, the "gap-filling," has been driven by the public demand for change. The authors also found that the institutionalization rates are generally lower in countries with higher levels of home care—a conclusion of relevance to the ongoing congressional debate concerning expansion of home and community-based care in the medicare and medicaid programs.

The committee would like to acknowledge the work of John M. Grana and Burton D. Dunlop, senior policy analysts, and Gail R. Wilensky, director of the Center for Health Affairs and vice presi-

dent of the Domestic Division of Project HOPE, in producing this study.

We hope that the information in this paper may advance our understanding and bring a wider range of experience to the national debate on how best to meet the needs of those elderly Americans who can no longer live unassisted.

JOHN HEINZ,
Chairman.
JOHN GLENN,
Ranking Minority Member.

EXECUTIVE SUMMARY

Despite historical differences in political and social traditions, the demographic pressures in the United States, Canada, and Europe are quite similar: On both sides of the Atlantic, the populations are aging and life expectancy is increasing. The inevitable result of these pressures is a dramatic surge in the need for long-term health and social services.

The United States and Canada are roughly 40 years behind Western Europe in the aging of their populations. While there are significant variations among the European nations' long-term care systems, their individual efforts offer a number of valuable lessons concerning care for the elderly.

In the 10 countries included in this comparative study, both higher per capita gross national product (GNP) and older populations are associated with a higher level of total public spending on the elderly, which includes pensions and long-term care as well as health care. Recent public spending on health care for the elderly is greater where there is a higher proportion of elderly in the population, especially those persons age 75 and older, but appears to be unrelated to per capita GNP. Where total public spending per elderly person is relatively low, there is general acknowledgement of a wide range of current needs for long-term care.

The countries studied have all of the services normally associated with the delivery of long-term care in the United States, although the relative distribution and use of these services varies significantly. Institutionalization of the elderly is very high in some countries and low in others; a few countries have moved very aggressively toward the development of congregate, sheltered, and other types of group housing; many countries have focused on the development of an extensive system of home and community based care. Notably, the range of perceived problems concerning the provision of long-term care in each of these countries is very similar to the range of problems known to exist in the United States. Many countries are in the process of filling identified service gaps.

In recent years, institutionalization rates have been generally lower in countries with higher levels of publicly provided home care. The degree to which this relationship reflects a substitution of service modes and the cost implications of such a trade-off are unknown. Institutionalization rates also are generally lower in countries with higher utilization of group quarters which is generally greater in countries with higher levels of publicly provided home care.

Long-term care reforms in these countries have been largely incremental rather than fundamental. They have taken the form of the expansion of services into areas where needs have not been

met; greater coordination of services, especially between health and welfare bureaucracies; the encouragement of an expanded role for the voluntary sector; decentralization of authority over financing and availability of services; and more extensive assessment of the needs of the elderly. In conclusion, the basic similarities to the United States long-term care system are more striking than the differences.

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LONG-TERM CARE IN WESTERN EUROPE AND CANADA: IMPLICATIONS FOR THE UNITED STATES

Chapter 1

BACKGROUND: DEMOGRAPHY AND HEALTH

In the Western industrialized countries, 1 in 7 persons is 65 years old or older. Expenditures for social programs, begun in an era when only 1 in 20 persons was old, are now accelerating and placing tremendous stress on national budgets. Since Western European countries are in advance of the United States and Canada in the aging of their populations, the efforts of these nations in caring for their elderly may prove instructive for North America. This report describes long-term care programs in Western Europe, the use of long-term care by the elderly and public expenditures on their behalf, the problems perceived by government entities charged with care of the elderly, and the initiatives countries have taken in light of those problems. Comparisons are made with long-term care programs in the United States and Canada, and implications for the future are discussed.

The selection of countries for this comparative report is based primarily upon the availability of data related to the long-term care utilization and expenditures. Thus, this study does not include data on several large Western European nations, notably Italy and Spain, due to the paucity of statistical information on the aged in those countries.

The data reported here are derived primarily from national budget documents, interviews with ministry officials, professional papers, articles and reports, and government reports to the 1981 World Assembly on Aging. Comparison of these data across countries, however, is hampered by definitional problems in two areas: What constitutes public and private expenditures; and what constitutes comparable services across countries, such as long-term care institutions or home care. To the extent permitted by the available documentation, care has been taken to insure that definitions across countries are reasonably similar before comparisons are made. Where such documentation is weak or indeterminate, it is so noted, and comparisons which are made should be considered tentative. In either case, strict comparability of data cannot necessarily be assumed, and the reader should interpret the findings of this report with caution.

DEMOGRAPHY

Historical and projected data on the elderly populations in the United States, Canada, and eight Western European countries are

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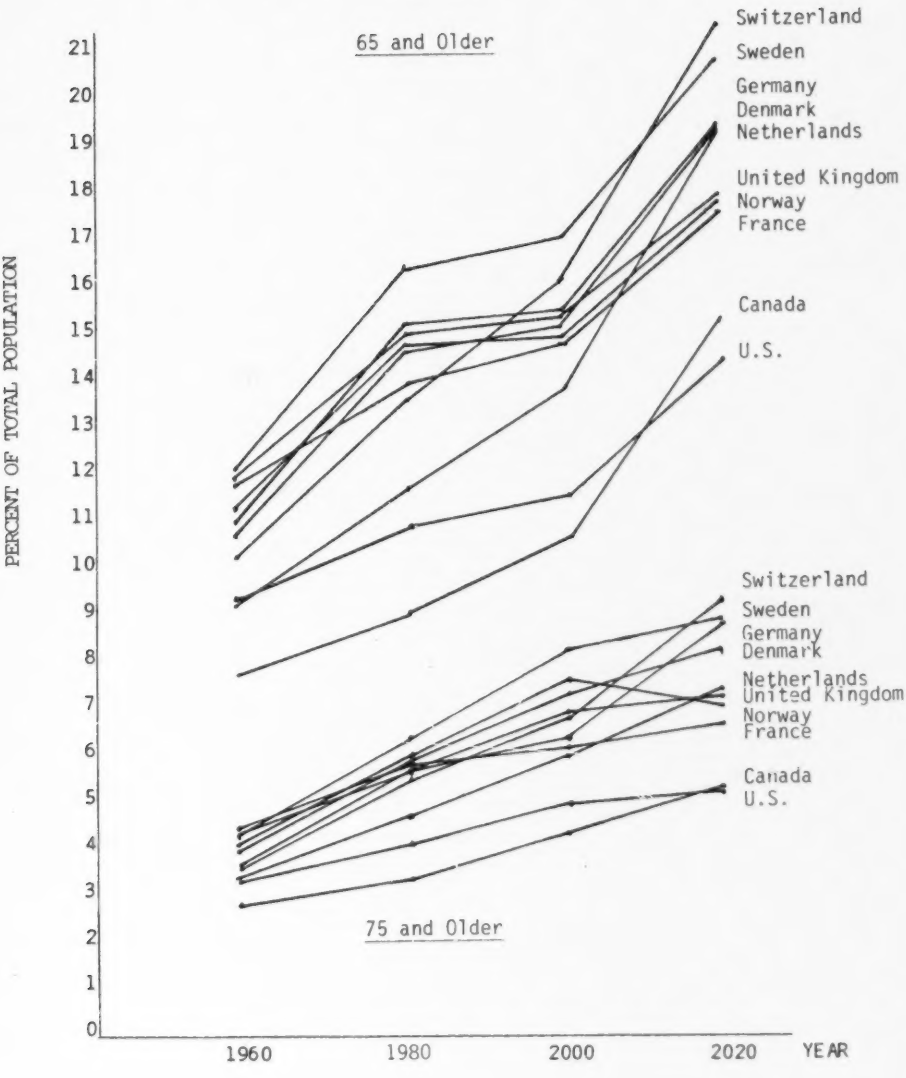
presented in table 1 and are graphed in figure 1 at three 20-year intervals between 1960 and 2020 (United Nations, 1982). Although breaking up the data into three arbitrary but equal segments may conceal important interim fluctuations, the patterns of demographic change observed in these 10 countries over the entire 60-year span are remarkably similar. The proportion of the population 65 and older increased in all countries between 1960 and 1980, but the rate of increase was significantly higher in Europe than in the United States and Canada. With the exception of Canada, Switzerland, and the Netherlands, this rate of growth is expected to slow markedly between 1980 and 2000. Between 2000 and 2020, all countries are expected to experience renewed rapid growth.

TABLE 1.—POPULATION AGE 65 AND OLDER AND AGE 75 AND OLDER AS PERCENT OF TOTAL POPULATION FOR SELECTED COUNTRIES, 1960–2020

Country	Year							
	1960		1980		2000		2020	
	65+	75+	65+	75+	65+	75+	65+	75+
United States	9.2	3.1	10.7	3.9	11.3	4.7	14.2	4.9
Canada	7.5	2.7	8.9	3.1	10.4	4.0	15.0	5.0
Denmark	10.6	3.7	14.3	5.5	14.7	6.7	19.0	7.6
France	11.6	4.3	13.7	5.6	14.6	5.9	17.4	6.3
Germany	10.8	3.5	15.0	5.5	15.4	6.0	19.2	8.4
Netherlands	9.0	3.1	11.5	4.4	13.5	5.7	18.7	6.9
Norway	11.1	4.0	14.6	5.7	14.6	7.1	17.5	6.6
Sweden	12.0	4.2	16.2	6.2	16.7	8.0	20.6	8.4
Switzerland	10.1	3.5	13.5	5.2	15.9	6.6	21.3	8.9
United Kingdom	11.7	4.2	14.9	5.5	15.3	6.7	17.7	6.9

Source: Demographic Indicators of Countries: Estimates and Projections as Assessed in 1980, (Medium Variant), Department of International Economic and Social Affairs, United Nations, 1982.

Figure 1


65 and Older
75 and Older
PERCENT OF TOTAL POPULATION
YEAR
1960
1980
2000
2020
0
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
Switzerland
Sweden
Germany
Denmark
Netherlands
United Kingdom
Norway
France
Canada
U.S.
Switzerland
Sweden
Germany
Denmark
Netherlands
United Kingdom
Norway
France
Canada
U.S.

Over the entire 60-year period, Canada, Switzerland, and the Netherlands will more than double their elderly populations, although these countries begin the period at different levels. The slowest growth over the period will be experienced by the United Kingdom, France, and the United States, where the elderly population will grow by slightly more than one-half. It can be seen that throughout the 60-year period the United States and Canada remain well below most of the European countries in the proportion of the population 65 and older and will not reach levels experienced in these countries in 1980 until the year 2020.

The growth in the proportion of the population 75 and over is dissimilar to the growth of the population 65 and older. As the bottom half of figure 1 demonstrates, the rate of growth of the 75 and older population will be virtually constant from 1960 through 2000 and, with the exception of Canada, the Netherlands, Switzerland, and Germany, will slow between 2000 and 2020. A net decline in the population who are old-old is projected for Norway. Again, the United States and Canada reach the lowest of the European levels of 1980 in the year 2020.

In terms of the aging of the population, then, the United States and Canada are roughly 40 years behind Western Europe. However, the high absolute numbers of old people in the United States and Canada, particularly those 75 years and older, make the problems associated with aging societies here only somewhat less immediate. Thus, the experience European nations have had in coping with a much older population may be instructive for the United States and Canada.

HEALTH

Table 2 shows recent life expectancy estimates at age 65 and at age 75 for selected countries. (Recent data for Switzerland are not available.) It can be seen that persons in these countries can expect to live from 13 to 19 years after age 65 and from 8 to 12 years after age 75. Life expectancy in the United States for both males and females at ages 65 and 75 is the highest for all countries shown in the table. In all of the studied countries, increases in life expectancy have been most dramatic for females, increasing from 2 to 3 years since the early 1950's; slight improvements have also occurred in male life expectancy in this period.

TABLE 2.—LIFE EXPECTANCY AT AGE 65 AND AGE 75 FOR SELECTED COUNTRIES

Country	Year(s)	Age 65		Age 75	
		Male	Female	Male	Female
United States	1979	14.30	18.70	9.00	11.80
Canada	1975–77	13.95	18.00	8.55	11.03
Denmark	1979–80	13.70	17.60	8.20	10.60
France	1978–80	13.81	18.07	8.20	10.63
Germany	1978–80	12.90	16.55	7.57	9.57
Netherlands	1979	14.00	18.20	8.60	10.90
Norway	1979–80	14.24	17.91	8.52	10.57
Sweden	1980	14.30	17.92	8.37	10.54
Switzerland	NA				
United Kindgom (England and Wales)	1977–79	12.60	16.80	7.50	10.00

Source: U.N. Demographic Yearbook for 1981 (1983).

Large reductions in infectious disease risk at early ages and general improvement in living conditions led to large increases in life expectancy for the entire population between 1940 and 1960. Rapid improvements in life expectancy at advanced ages since 1960, though, are the result of entirely different mechanisms. In the United States, these improvements in survival rates for older persons are believed to be the result of the slowing of the rate of progression of chronic diseases, rather than the elimination of their lethal consequences (Manton, 1982). This means that the aging of the population will be accompanied by a greater prevalence of chronic disease. However, at any given age, each chronic disease may not necessarily be as severe nor produce as great a level of dependency as has been the case in the past.

Comparative data are not available on either chronic conditions or dependency across countries, so it is not possible to determine the extent to which variation in these factors influences the types and quantities of long-term care provided. Nevertheless, the significant impact on public budgets of a larger elderly population is suggested by nationally available data. In the United States, for example, the prevalence of chronic conditions is nearly twice as great for the elderly as it is for persons 45 to 64 years of age, and five times as great as for persons 17 to 44 years (Department of Health and Human Services, 1981). In the United Kingdom, per capita spending on health care is at least twice as great for persons 65 and older as for persons of all ages (United Kingdom Central Statistical Office, 1982); in the United States, it is nearly three times as great (Fisher, 1980).

The prevalence of activity limitation and the need for assistance in the activities of daily living also rise dramatically with age. In the United States, persons age 65 and older are almost five times more likely to suffer activity limitation than persons under 65 years, and persons age 85 and older are twice as likely to suffer activity limitation as persons age 65 to 74. Persons age 75 and older are over 20 times more likely to need personal care assistance in at least one activity of daily living (such as bathing, dressing, eating and toileting) than are persons under age 65 (Health Care Financing Administration, 1981). Thus, in addition to a growing need for acute care, an aging population also will be accompanied by a growing need for long-term and maintenance care, including a vast array of social services as well as personal care. If current age-specific rates of activity limitation and nursing home utilization were to hold between 1980 and 2040, the number of aged persons with limitations in activities of daily living is projected to increase 233 percent and the number of nursing home residents will increase 279 percent (Rice, 1983).

Chapter 2

EXPENDITURES FOR THE ELDERLY

Differences in the economies of countries, as well as in the demographics of their populations, may affect the level or type of support for the elderly. The association between gross national product (GNP) and spending on health, for example, is well known.

There are several important differences in the economies of the countries in this study. One difference is the large variation in GNP per capita across the countries studied. In 1980, GNP per capita ranged from approximately $8,500 in the United Kingdom to nearly $16,000 in Switzerland (table 3), with the United States falling in the middle of the range. These differences in available resources are likely to affect the amount of support for the elderly. There is also large variation in recent economic growth rates of these 10 economies (table 3). Slower economic growth is likely to be accompanied by the need for other public programs which compete with programs for the elderly.

TABLE 3.—CHARACTERISTICS OF THE ECONOMIES OF SELECTED COUNTRIES

Country	1980 GNP [1] per capita U.S. dollars	Economic [2] growth rates		Percent females [3] economically active			
		1964–74	1974–81	Year [4]	Percent	Year [5]	Percent
United States	11,590	4.2	3.6	1960	24.6	1981	39.8
Canada	10,180	7.0	3.4	1961	19.7	1980	37.6
Denmark	12,010	4.5	2.2	1960	27.9	1981	45.7
France	11,200	6.5	3.0	1962	27.6	1981	33.0
Germany	12,320	4.6	2.8	1961	33.2	1981	33.3
Netherlands	11,010	6.2	2.8	1960	16.1	1981	24.1
Norway	12,830	5.1	5.7	1960	17.8	1981	39.7
Sweden	13,730	4.2	1.4	1960	25.7	1980	46.5
Switzerland	15,980	4.2	0.5	1960	27.4	1980	34.6
United Kingdom	8,520	2.9	0.9	1960	29.3	1980	35.9

[1] "1983 World Bank Atlas: Gross National Product, Population, and Growth Rates." Washington, 1983.
[2] Average Annual Growth in Real GNP or GDP; "International Financial Statistics Yearbook," International Monetary Fund. Washington, 1983.
[3] "Year Book of Labour Statistics." International Labour Office. Geneva, 1982.
[4] Includes all employed and unemployed females.
[5] Includes employed and unemployed females ages 15 and older for Canada, France, Germany, Denmark, and the Netherlands; for all other countries the figures represent total females.

An important development in most Western industrialized economies has been an increase in labor force participation by women over the past 20 years. For this period, growth in the proportion of females economically active has ranged from 0.5 percent in the Federal Republic of Germany to over 120 percent in Norway; economic activity rates by females have grown by more than 90 percent since 1961 in Canada, and by more than 60 percent since 1960 in the United States. Because greater activity in the formal economy by the traditional caregivers to elderly adults is believed to be a major factor in the growth of extrafamilial provision of long-term care, public and private, these differences may have an impact on the need for greater public spending for the elderly. This factor may become more important as more people with moderate and

severe impairments live longer. In almost all of the countries studied, over one-third of all females (females age 15 and older in Canada, France, Germany, Denmark, and the Netherlands) are now economically active. The percent of females economically active ranges from a low of 24 percent in the Netherlands to a high of 46 percent in Denmark and Sweden. Most of the countries fall in the 33- to 40-percent range.

PUBLIC EXPENDITURES ON HEALTH CARE FOR THE ELDERLY

The rapid aging of Western industrialized societies over the past 20 years has been paralleled by a rapid growth in expenditures for health care. As table 4 shows, the percent of gross domestic product (GDP) spent on health has grown from the 4- to 6-percent range in 1960 to the 7- to 10-percent range in 1980. Public expenditures for health have grown even more dramatically, doubling or tripling their share of GDP since 1960 in most of the study countries (public expenditures include central, State, provincial, and local direct governmental spending on health care as well as government investment and capital spending on health care facilities; presumably, as the European countries report them, these data do not necessarily include income-support programs such as disability allowances for long-term care). To some extent this increase in public expenditures reflects conscious government policy, but it also reflects increases in medical care costs, improvements in technology and increases in the intensity of services, and the burden of a growing elderly population. In the United States, for example, medicare's hospital expenditures are driven primarily by rising hospital costs. These costs are expected to account for 10.8 percentage points of the 13.2-percent annual projected growth in hospital expenditures for medicare beneficiaries while aging of the population accounts for 2.2 percentage points (Ginsburg and Curtis, 1983).

TABLE 4.—SHARE OF HEALTH EXPENDITURE IN GDP 1980[1] FOR SELECTED COUNTRIES

Country	Total health expenditure as percent of GDP			Public health expenditure as percent of GDP			Public expenditures as percent of total, 1980 [2]
	1960	1980	Percent change	1960	1980	Percent change	
United States	5.3	9.5	79	1.3	4.0	208	42.1
Canada	5.5	7.2	31	2.4	5.6	133	77.8
Denmark	N.A.	7.8	.....	3.6	6.2	72	79.5
France	4.3	8.0	86	2.5	6.1	144	76.3
Germany	4.5	8.0	78	3.1	6.2	100	77.5
Netherlands	3.9	8.3	133	1.4	6.5	364	78.3
Norway	3.7	6.7	81	2.8	5.6	214	83.6
Sweden	4.7	9.6	104	3.4	8.8	159	91.7
Switzerland	N.A.	7.3	.....	N.A.	4.7	.....	64.4
United Kingdom	4.0	5.7	43	3.4	5.2	53	91.2

[1] Or nearest year available.
[2] Public expenditure as percent of total.
Source: "Expenditure on Health Services." Organization for Economic Co-operation and Development. Paris. April 1983 (Draft).

Table 4 also indicates that the United States is at the low end of the range for the proportion of total health expenditures paid from

public funds. Eight of the ten countries listed pay from 76 percent to 92 percent of total health expenditures from public funds, about twice the level of the U.S. rate. Switzerland falls between these extremes. The United States thus relies more heavily than all of the other countries shown on the private sector for the financing of health care. Although the major medical care program for the elderly in the United States, medicare, is primarily public, the elderly still pay out of pocket for approximately 55 percent of their total health care costs.

Although the elderly represent from 10 to 15 percent of the populations of the 10 study countries, public expenditures for health care for older people range from 20 to 50 percent of total public expenditures on health (table 5). (The term "public" used in table 5 may not be comparable to that used in table 4, as the sources of data differ; comparisons based on these data, therefore, are tentative.) The percent of GNP devoted to public health care expenditures for the elderly shown in table 5 appear to be strongly related to the proportion of elderly in the population. Exceptions are Switzerland, where GNP per capita is very high and private expenditures play a more important role, and the United Kingdom, where total health care expenditures are limited by government budget authorization. There is no apparent relationship between the percentage of GNP devoted to public health care for the elderly and GNP per capita. There is wide variation in the estimated public health care expenditure per capita on the elderly across countries, from under $1,000 per old person in the United Kingdom to about $2,500 per old person in Norway. Public health care expenditures per elderly person appear to be generally higher in countries with more persons age 75 and older.

TABLE 5.—PUBLIC HEALTH CARE EXPENDITURES FOR THE ELDERLY

Country	Public health care expenditures in 1980 as percent of GNP [1]	Percent of public health expenditures devoted to the elderly	Public health expenditures for the elderly as percent of GNP	Estimated per capita public health care expense for elderly (U.S. dollars)
United States	3.9	[2]29	1.1	1,212
Canada	5.8	[3]21	1.2	1,370
Denmark	6.4	[4]43	2.8	2,356
France	6.1	[5]35 to 40	2.3	1,876
Germany	6.2	NA	.....	.....
Netherlands	6.5	[6]25	1.6	1,534
Norway	5.8	[7]50	2.9	2,546
Sweden	8.9	NA	.....	.....
Switzerland	4.5	[8]25	1.1	1,303
United Kingom	5.2	[9]33	1.7	975

[1] "Expenditure on Health Services." Organization for Economic Co-operation and Development, Draft, Paris, April 1983, and International Financial Statistics Yearbook. International Monetary Fund, Washington.

[2] (1978). Fisher, Charles R., "Differences by Age Groups in Health Care Spending," Health Care Financing Review, Volume 1, Issue 4, U.S. Health Care Financing Administration, Spring 1980.

[3] (1976). "Canadian Governmental Report on Aging," June 1982, for the World Assembly on Aging, July 26–August 6, 1982.

[4] (1980). Uldall, Peter, "The Elderly's Consumption of and Contribution to the Gross Domestic Product in Denmark," "Danish Medical Bulletin," Vol. 29, No. 3, March 1982.

[5] (1980). Hospital expenditures only, "Aging in France," 1982, World Assembly on Aging.

[6] (1978). "Netherlands National Report on Aging Policy," World Assembly on Aging, 1982 (for ages 70 years and older).

[7] (1981). "The Aging in Norway: Humanitarian and Developmental Issues," Planning Group for Norwegian Participation in United Nations World Assembly on Aging, Royal Norwegian Ministry of Health and Social Affairs, 1982.

[8] (1980). "Budget Incidence, Demographic Change and Health Policy," by R. E. Leu and Rene L. Frey, paper presented at the 39th I.I.P.F. Congress on Public Finance and Social Policy, Budapest, Hungary, 22–26 August 1983.

[9] (1980). England only, "Planning Long-Term Care Insurance in Israel," Brenda Morginstir. and Nira Shamai, for the Expert Group Meeting on Long-Term Care of the Elderly and the Disabled, International Social Security Association, Oslo, June 1983.

TOTAL PUBLIC EXPENDITURES ON THE ELDERLY

Statistics on total expenditures by or on behalf of the elderly are not available. Total public expenditures on the elderly, which include pensions and long-term care as well as acute health care, as a percent of GNP are detailed in table 6. In contrast to public health care expenditures, total public expenditure on the elderly as a proportion of GNP appears to be directly related to both the percent of the population 65 and older and GNP per capita. Not surprisingly, an important determinant of the level of public social programs for the elderly appears to be a country's wealth. There is a wide variation in total public expenditures per elderly, ranging from a little over $4,000 per elderly person in the United Kingdom to nearly $16,000 per elderly inhabitant in Switzerland. For the countries in the study, the percent of females active in the economy is not significantly related to spending for the elderly.

TABLE 6.—TOTAL PUBLIC EXPENDITURES ON THE ELDERLY AS A PERCENT OF GNP FOR SELECTED COUNTRIES

Country	Year	Percent GNP	Total per capita public expenditures for the elderly (U.S. dollars)
United States [1]	1981	5.9	6,366
Canada [2]	1982	5.4	[3] 6,096
Denmark [4]	1980	10.1	8,499
France [4]	1980	9.8	7,993
Germany	NA		
Netherlands [5]	1982	8.2	7,861
Norway [4]	1981	5.7	5,005
Sweden [4]	1982	[6] 14.5	12,293
Switzerland [7]	1980	13.4	15,878
United Kingdom [8]	1980	7.7	4,416

[1] (1981). "Final Report of the 1981 White House Conference on Aging: Volume 1, A National Policy on Aging," 1981.
[2] (1982). Policy, Planning and Information Branch, Health and Welfare, Canada, Government of Canada, November 1983.
[3] Does not include social services.
[4] (1980). Country Report for the World Assembly on Aging, 1982.
[5] (1982). H. G. De Gier, "An Overview of the Dutch System of Long-Term Care of the Elderly and the Disabled," paper presented at the Expert Group Meeting on Long-term Care of the Elderly and the Disabled, International Social Security Association, Oslo, June 1983
[6] Estimate.
[7] (1980). "Budget Incidence, Demographic Change and Health Policy," by R. E. Leu and Rene L. Frey, Paper presented at the 39th I.I.P.F. Congress on Public Finance and Social Policy, Budapest, Hungary, 22–26 August 1983.
[8] (1980). "The Government's Expenditure Plans 1982–83 to 1984–85," Comnd. 8494–II, Her Majesty's Stationery Office, London, 1982, and "Social Trends—12," Government Statistical Service, HMSO, London, 1982.

In summary, available data give some insight into public spending for care of the elderly. It appears that public expenditures on health care for the elderly as a percent of GNP are related to the proportion of elderly in the population. These expenditures are lower in some countries either because of outright limitation on the total health care budget or because of greater reliance on private sector financing. The variation across countries in total public spending for the elderly as a percent of GNP is related to a country's wealth. In countries where total public spending per elderly person is relatively low, there is general acknowledgment of a wide range of unmet needs for long-term care.

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Chapter 3

LONG-TERM CARE FOR THE ELDERLY

All of the countries in this study have to varying degrees all of the services normally associated with LTC provision in the United States: Long-term care or chronic disease hospitals or geriatric wings of acute care hospitals, nursing homes,[1] old age, or personal care homes, congregate and sheltered housing, home health care, homemaker care, adult day care, respite care, and the like. The relative distribution and use of these services, which varies across the countries, are described in this chapter, along with differences in organization, financing, and perceived problems. (Long-term care programs in the western European countries and Canada are described briefly in the appendix.)

THE DISTRIBUTION OF LONG-TERM CARE SERVICES

The United Kingdom and Sweden, for example, make relatively heavy use of home-based care (and, indeed, make it universally available according to dependency level) while France, Canada, Norway, and Switzerland make relatively greater use of old age homes. France, the United Kingdom, and, to a lesser extent, Sweden, possess more geriatric hospital or geriatric hospital ward capacity than the other countries. Sweden, in particular, and the United Kingdom and the Netherlands also have considerable sheltered housing stock. France and Germany apparently still make heavy use of psychiatric hospitals for care of the mentally impaired elderly. The United Kingdom, Denmark, and the Netherlands have emphasized the use of day care centers. It appears that the United Kingdom is the only country where provision of respite care is a significant component of the long-term care continuum. The British utilize day hospitals and other short-term care facilities heavily for this purpose. Relative to other countries, the United Kingdom also places strong emphasis on rehabilitation in all settings (Ageing in the United Kingdom, 1981; Kamerman, 1976). Danish municipalities are now required to establish day care centers in which physical therapy and occupational therapy can be provided to the elderly (Erdal, 1982).

Two countries have pursued a service which appears unique. France has arranged for temporary stays of 1 to 3 months in hospitals and for temporary sheltering units in various other settings such as nursing homes and old age homes in order to smooth the

[1] Nursing homes in Europe appear to be considerably more specialized settings than they are in the United States. They may be equivalent to the typical skilled nursing facility but probably not the typical intermediate care facility in this country. In some countries they appear to provide a service level of greater intensity than SNF's.

transition of certain old persons from the hospital back to home living. Denmark has set up long-term medical treatment units in acute hospitals for temporary stays (1 to 3 months) in order to administer rehabilitation therapies and, most importantly, to conduct through assessments of health status and care needs of elderly persons potentially in need of long-term care.

Among the Western European nations, it appears that a broader spectrum of services is available and accessible in the Scandinavian countries, the Netherlands, and in the United Kingdom than in Germany or France. In general, however, the Western European countries seem to have made less use of nursing homes and more use of sheltered housing and geriatric and psychogeriatric ward in psychiatric hospitals for the care of impaired elderly than is the case in this country. Several of the Western European countries also make more use of home health services.

STRUCTURE OF THE LONG-TERM CARE SYSTEM

There are some noteworthy differences in the way long-term care services are organized and administered in the countries studied. Long-term care in the Scandinavian countries, the United Kingdom, and the Netherlands is provided almost exclusively by the public sector, either directly or indirectly through governmental subsidies to voluntary organizations. Germany and Switzerland, on the other hand, resemble the United States more closely in that proprietary firms play a prominent role in the direct provision of long-term care services, and the private sector (older persons and their families) plays a more prominent role in financing these services. Proprietary nursing homes also play a prominent role in the provision of long-term care services in Canada, but most other services and financing are provided by the public sector.

Long-term care includes the provision of both medical or health services and welfare or social services as they have been traditionally defined. In Western Europe, as in the United States, the administration of public long-term care programs typically is divided between the medical or health bureaucracy and the public welfare or social service bureaucracy. This split reinforces similar schisms across countries in the programmatic treatment of short term or acute care versus long-term care and of nursing home versus home-based care. In general, medically related services and care settings such as geriatric hospital care, nursing home care, home health care, and physician care fall under the aegis of the health administration (like medicare and medicaid for publicly funded patients in the United States), while such entities as old age homes, and home help care are administered by the welfare or social service authority (like social services programs under the DHHS Office of Human Development Services and its State and local counterparts in the United States). Sheltered housing, sometimes viewed as a third principal component of the long-term care services system, often falls under a third bureaucratic umbrella as it does in the United States (usually the U.S. Department of Housing and Urban Development, and the local housing authority and nonprofit organizations that are the principal conduits for HUD funds).

The administration of the medically related components of care tends to be more standardized and focused at a higher level of government than does the administration of social service or custodial elements. Due to differences in historical development, the central government or the political unit equivalent to our States is more often responsible for administering medical care while social service delivery is more a responsibility of the municipalities. In Sweden, for example, the county councils are charged with providing medical care while the local councils are responsible for welfare and social services. This arrangement resembles that in the United States, although the demarcation between State responsibility for medical services (except in the area of licensing and inspections, perhaps) and county or municipal responsibility for social services is not as clear cut here. State social services departments, for example, play a relatively heavy role in shaping and monitoring local social service delivery.

As a rule, however, the municipalities in the European countries, especially in Sweden, are more heavily involved (and increasingly so, it seems) in the administration of both health and welfare components of long-term care delivery than they are in the United States, again largely for historical reasons (Trier, 1982). They also are responsible for contributing a larger share of the costs of providing formal long-term care than is typical for local jurisdictions in this country. The central government's share of funding often goes directly to the municipality rather than being funneled through an intermediate government body as it is here where the States function as the intermediaries responsible for matching Federal funds.

FINANCING

The division of long-term care administrative responsibility parallels fairly closely the division between the health and the welfare dollar in these countries, as it does in the United States. The national health service in the United Kingdom and the national health insurance schemes in the other countries all cover services for their long-term care populations but, in most cases, only those services which are directly health or medical components. In Denmark, for instance, national health insurance covers only nursing home care, visiting health service, and physician visits (Almind, 1982). In France, this fiscal dichotomy cuts across even particular settings. Under recent French legislation, national health insurance there will pay the medical treatment portion of care in a medical care section of a nursing home or in a hospital but some of the reimbursement to the hospital or nursing home for room and board must come from other sources such as family or public welfare (Secrétariat D'État Chargé Des Personnes Agées, 1982). The national social health insurance scheme in Sweden, at the opposite extreme, reimburses municipalities for all costs of providing long-term care, as health care there is viewed as a subcategory of "social welfare policy" (National Commission on Aging, 1982).

The national insurance schemes may pay differential portions of the costs of services covered. The insurance plan in Norway, for example, will reimburse counties or municipalities for 50 percent of

nursing home costs and home help costs but for 75 percent of home nursing costs. The counties or municipalities are responsible for the remaining portion of the service costs. In Canada, the provinces are reimbursed for 50 percent of the costs of social services (public funds which are paying for most of the other 50 percent as well).

The mechanism that the state employs for reimbursing the localities varies relatively little. Norway, for example, provides block grants to the counties for health care services and maintenance of health institutions, and to the municipalities for the provision of social services. Most central governments, however, appear to reimburse the localities retrospectively for costs incurred, as the United States has done almost exclusively until quite recently.

SPECIAL FEATURES

Several other features of the long-term care programs in European countries deserve special mention.

Denmark, Sweden, and the Netherlands, as well as the United Kingdom and some Provinces in Canada, have formal screening mechanisms to control admissions to long-term care institutions. Denmark and Sweden formally screen all candidates for admission. Denmark has set up local multidisciplinary assessment committees just for this purpose (Dalgaard, 1982). The Netherlands, as well, employs very restrictive screening criteria in order to insure that openings in residential homes are reserved for the more severely impaired population (International Steering Committee on Aging Policy, 1982).

Another service which has generated considerable policy discussion (but the establishment of only three major state programs) in the United States, and for which at least four of the European countries have explicit policy in place, is caregiver assistance. In Sweden, the United Kingdom, and Germany relatives may be paid to provide care. A significant proportion of all home help aides in Sweden are relatives of elderly persons receiving service. Increasingly, they are being paid by the local councils at the rate for nurses' assistants rather than at the rate for home help aides (National Commission on Aging, 1982). Moreover, a National Committee on Care by Relatives recently established there is considering the feasibility of coverage of family caregiving under Sweden's national health insurance (National Commission on Aging, 1982). The United Kingdom has a invalid care allowance which can go to informal caregivers, and Germany has a program of caregiver reimbursement. Canada may be the only one of this group of countries which has a family supplementation requirement on the books in all of its provinces, but this provision is rarely enforced. Canada has no explicit provision for paying the families of impaired elderly to provide care except for allowing a limited tax deduction to single persons who care for a dependent older relative (Canadian Governmental Report on Aging, 1982).

Finally, all of these countries except Canada provide cash grants or constant attendance allowances to impaired elderly persons who can use this allowance to purchase needed care or anything else they deem useful for coping with their impairments. The grants are often the first public intervention a person receives after the

onset of disability. Attendance allowances in social assistance or welfare programs represent an average of 10 to 25 percent of gross average monthly earnings for production workers in five of the study countries, and in social insurance and special aging programs from 25 to 50 percent of earnings, with higher allowances in cases of very great disability. The use of attendance allowances in the United States is limited largely to two small programs (called "housebound" and "aid and attendance" allowances) under the Veterans' Administration (Grana, 1983).

PERCEIVED PROBLEMS

More familiar to Americans, perhaps, than the description of the structure of long-term care in these countries is a litany of serious problems that seem to exist there and, indeed, that appear to dominate the policy discussion surrounding long-term care just as they do here. The most visible of these problems seem to parallel very closely those identified in the United States.

Organizationally speaking, lack of coordination seems almost endemic to the provision of long-term care to impaired individuals. This situation is hardly surprising given the typical split in fiscal and administrative responsibility. Interestingly, this problem receives somewhat less attention in available materials on Sweden and Denmark, where the municipalities are charged with administering both health and welfare services (The National Commission on Aging, 1982; Danish Medical Bulletin, 1982).

Given the relative costs of care provision associated with different care modalities, the one problem that seems to be creating concern in virtually all of these countries is the problem of heavy utilization or inappropriate use of hospital care for the chronically ill elderly population—although this particular problem appears to elicit more alarm in some countries than in others. Several countries make far greater use of both acute (and psychiatric) hospitals for care of the elderly than is the case in the United States. In the United Kingdom and Denmark, for example, at least 40 percent of the acute hospital beds are filled by elderly patients (Nusberg, 1983). A major common contributor to inappropriate utilization of acute hospitals for chronic care seems to be, as it is in the United States, the fact that hospitalization is almost always fully covered under insurance schemes whereas insurance coverage for nursing home care or other alternatives is partial at best, so that funding is more cumbersome and often less certain and less generous.

Also, a shortage of nursing home capacity for the provision of long-term care is clearly a major difficulty in several of the countries reviewed. The United Kingdom reports a shortage of both nursing home and geriatric hospital bed capacity. The United Kingdom is "experimenting" with the feasibility of using public nursing homes to care for aged persons "needing continuing long-term nursing which does not require the full range of hospital facilities but which cannot be provided through the community health services" (Ageing in the United Kingdom, page 16). France points to the backup in acute hospital beds of patients awaiting placement in a nursing home. At the same time, France perceives an overuse of psychiatric hospitals for care of the elderly (Secrétar-

iat D'État Chargé Des Personnes Agées, 1982). The Netherlands perceives a very severe shortage there in the availability of specialized psychogeriatric nursing home capacity (Interministerial Steering Committee on Aging Policy, 1982). In Germany, the shortage of nursing home beds has led to substantial conversion of general hospital wings into chronic disease or geriatric wings. Germany also reports very limited day care capacity (German Centre of Gerontology, 1982). Canadians, on the other hand, feel that their system is already biased toward the use of nursing homes relative to alternative care modes (Canadian Governmental Report on Aging, 1982) and Denmark reports a shortage only in Copenhagen, although that country's bed stock is growing, and the Danes are systematically replacing older, private facilities with modern, standardized, publicly operated homes.

The first of these two problems might provide a potential solution to the second. Since most of these countries have excess hospital capacity and since hospital care appears to be significantly less expensive than it is in the United States, use of acute care beds for chronic care might prove to be a rational, cost-effective strategy to pursue. Any additional costs of operating acute care beds over nursing home beds might be offset by significant savings realized from not having to construct as many nursing home facilities.

The Germans and the French lament the lack of rehabilitation in the nursing homes that do exist. All the countries publicly express their dissatisfaction over the general absence of interest and active involvement of the medical profession in the provision of long-term care and the dearth of professionals and paraprofessionals who are trained to serve the impaired elderly. Finally, according to a recent survey undertaken in Denmark, serious gaps in awareness concerning services that are available to assist impaired persons in maintaining independence outside of an institution appear to exist among the aged population. As indicated, all of these major problems identified by the Europeans and the Canadians have a decidedly familiar ring to American policymakers.

PATTERNS OF LONG-TERM CARE UTILIZATION

The definition of an institutional setting varies across countries, although all institutions have the common feature of the provision of room and board, and many are designed to accommodate the functional requirements of daily life. They differ in the variety and intensity of health and personal care offered to patients. Variations in services provided in these settings across countries make comparisons difficult and tentative. For the purposes of this study, institutions are defined as settings known in the United States as nursing homes, homes for the aged, and chronic and psychogeriatric care beds or wards in hospitals. They are called many different names—such as residential homes in the United Kingdom, and homes for special care in Canada. Available literature was searched for information on the proportion of persons 65 years old and older in institutions, and reasonably comparable figures are presented in table 7. Institutional settings were selected which best correspond to long-term care institutions in the United States. Institutionalization rates vary from a low of 3.1 percent in Sweden to

a high of 7.1 percent in Canada (excluding an additional 1.4 percent of the elderly in Canada who are in hospital beds for less than 1 month and perhaps waiting for a bed in a nursing home); the unweighted mean for all 10 countries is approximately 5 percent.

TABLE 7.—POPULATION AGE 65 AND OLDER IN INSTITUTIONS AND GROUP LIVING QUARTERS AS PERCENT OF TOTAL POPULATION 65 AND OLDER FOR SELECTED COUNTRIES

Country	Year	Percent of elderly in—		
		Institutions	Group quarters	Institutions and group quarters
United States [1]	1980	5.3	0.5	5.8
Canada	1978	[2] 7.1	1.6	[3] 8.7
Denmark [4]	1980	5.3	0.9	6.2
France [5]	1980	5.2	1.4	6.6
Germany [6]	1980	3.6	0.9	4.5
Netherlands [7]	1980	4.0	7.1	11.1
Norway [8]	1981	5.1	5.7	10.8
Sweden [9]	1981	3.1	6.1	9.2
Switzerland [10]	1976	5.7	NA	NA
United Kingdom [11]	1980	3.9	5.4	9.3

[1] Unpublished data, U.S. Census, 1980.
[2] Based on Schwenger, Cope W. and Gross, M. John, "Institutional Care and Institutionalization of the Elderly in Canada," in Victor W. Marshall, Aging in Canada: Social Perspectives, Fitshenry and Whiteside, Toronto, 1980 (excludes data on Northwest Territories, Yukon, and Quebec), Policy, Planning and Information Branch, Health and Welfare, Canada.
[3] Based on 1976 Canada Census, and Presentation by Cope W. Schwenger, Final Plenary Session, National Conference on Aging, Ottawa, October 1983, Policy, Planning and Information Branch, Health and Welfare, Canada.
[4] "Social Services for the Elderly," Inger Erdal, and, "Institutions for the Elderly: Present State and Development Trends," Ernest Andersen, Danish Medical Bulletin, Vol. 29, No. 3, March 1982.
[5] Aging in France, 1982, World Assembly on Aging (group quarters include sheltered housing).
[6] Report on the Situation of the Elderly in the Federal Republic of Germany, May 1982, German Center for Gerontology, World Assembly on Aging.
[7] Netherlands National Report on Aging Policy, July 1982, World Assembly on Aging.
[8] The Aging in Norway: Humanitarian and Developmental Issues, World Assembly on Aging, 1982 (not including hospital beds).
[9] Just Another Age, Swedish Report to the World Assembly on Aging, 1982, The National Commission on Aging.
[10] Rentiers AVS: Une autre image de la suisse, Pierre Gilliand, Realites Sociales, Lausanne, 1983.
[11] "Research into the Long-Term Care of Elderly People in the United Kingdom," Patricia M. C. Winterton, 1 presented at the Expert Group Meeting on Long-Term Care of the Elderly and Disabled, International Social Security Association, Oslo, 20–22 June 1983, and Social Trends 12. Central Statistical Office. Government Statistical Service. Her Majesty's Stationery Office, London, 1983; (includes long-term care wards in hospitals), and Growing Older, Cmnd. 8173, HMSO, London, March 1981.

Many old persons do not need health care and constant maintenance, but require social and domestic services or personal care to lead independent lives outside of institutions. Some live in group quarters where food and sometimes services are either provided or available. Group quarters are often referred to as "congregate housing," "sheltered housing," and "near institutions"; all of these are utilized to varying degrees by elderly in the study countries. Although group quarters are even less comparable across countries than are long-term care institutions, an estimate of the proportion of the elderly in group quarters is also presented in table 7. It can be seen that in countries with relatively low institutionalization rates, such as Sweden, the Netherlands, and the United Kingdom, the proportion of elderly in group quarters is generally higher, and vice versa. It appears that service-enriched group quarters may be used as alternatives to institutional care for some proportion of impaired or dependent elderly.

As stated above, a major thrust in most countries is the provision of more home care so as to maintain the elderly in the community rather than in an institution. In many cases, the commitment to long-term care outside of institutions for as many impaired elderly as possible is an explicit government policy. Home care is viewed

as a more humane and more cost-effective form of care than institutional care. Information on publicly provided homemaker/home help care and home nursing/domiciliary care has been combined in table 8 to form a single representative figure for the public commitment to publicly provided home care in a country: The number of cases of home care per thousand elderly. As table 8 indicates, there is wide variation across the study countries in the amount of public home care provided, from a low of 8 cases per thousand elderly in Switzerland to a high of 291 cases per thousand in the United Kingdom. Provision of public home care is generally high in Sweden, the Netherlands, and the United Kingdom, and low in Switzerland and France. France is currently developing a larger home care system. Data on homemaker/home help care were not available for Germany, and the figure for the number of home care cases per thousand elderly there is artificially low.

TABLE 8.—PUBLIC HOME CARE FOR THE ELDERLY SELECTED COUNTRIES

[Number of cases of beneficiaries]

Country	Year	Homemaker/ home help care	Home nursing/ domiciliary care	Total home care	Number of cases per thousand elderly
United States	1978	[1] 2,297,625	[2] 889,000	.....	136.5
Canada [3]	1982	.....	.....	55,506	24.3
Denmark [4]	1979	.....	.....	110,000	152.7
France [4]	1980	380,000	3,000	.....	52.1
Germany [5]	1975	NA	230,000	.....	[6] 26.0
Netherlands [4]	1979	105,404	264,913	.....	233.2
Norway	.....	.....	.....	NA	.....
Sweden [4]	1980	307,000	[7] 41,000	.....	259.7
Switzerland [8]	1980	.....	.....	7,210	8.1
United Kingdom [9]	1980	809,000	1,610,000	.....	291.4

[1] State Title XX Plans for 1980, Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, Washington (overestimate: 1,538,625 clients of "home based services"; elderly clients not separable from total), and State Program Performance Report for Title III of the Older Americans Act, Administration on Aging, Office of Human Development Services, U.S. Department of Health and Human Services, Washington, 1978 (includes "in-home services").

[2] Health Care Financing Program Statistics: Medicare Summary, Use and Reimbursement by Person, 1976–1978. August 1982, and Health Care Financing Program Statistics: The Medicare and Medicaid Data Book, 1981. April 1982, Health Care Financing Administration, U.S. Department of Health and Human Services, Office of Research and Demonstrations.

[3] Policy, Planning and Information Branch, Health and Welfare, Canada, November 1983 (underestimate based on average cases per month).

[4] Government Report to the World Assembly on Aging, 1982.

[5] "Long-Term Care of the Elderly and Disabled in the Federal Republic of Germany," Franz Josef Oldiges, paper presented at the Expert Group Meeting on Long-Term Care of the Elderly and Disabled, International Social Security Association, Oslo, 20–22, June 1983.

[6] Underestimate.

[7] Total; elderly not separable from total clients.

[8] Soins a Domicile, L. Ramel, C. Willa and P. Gilliand, Realites Sociales, Lausanne, 1982.

[9] Social Trends—12, Central Statistics Office, Government Statistical Service, Her Majesty's Stationery Office, London, 1983. Data on persons age 65 and older were obtained from Demographic Indicators of Countries: Estimates and Projections as Assessed in 1980, United Nations, 1982; data for interquinquennial years were derived by linear interpolotion.

These data do not account for privately financed home care, and therefore under-report the total utilization of home care in a country (such data are not available). However, the figures in table 8 also under-report the public commitment to home care to the extent that home care is purchased privately with support received from the public sector in the form of cash (that is, services are not pruchased or reimbursed for directly by the public sector). This phenomenon probably occurs more in countries which provide cash disability allowances for long-term care, or relatively large pension benefits. The effect may be greatest in Germany which, it has been suggested, stresses an income strategy as basic social policy for the aged (Kahn and Kamerman, 1976).

Chapter 4

PROGRAM INITIATIVES

A number of experiments to deal with perceived problems in the existing long-term care systems in this country have been launched in recent years; for example, medicare 222 projects, channeling demonstrations, and medicaid home and community care waivers. Long-term care program initiatives also have been undertaken recently in virtually every other Western industrialized country, sometimes as experiments and sometimes as permanent programmatic alternatives. Although the number and scope of these innovations are small relative to the problem, they provide a sense of the ways in which these countries are attempting to deal with their growing responsibilities in the care of impaired individuals among their aged populations. In this chapter, we will look specifically at initiatives underway in the areas of coordination, voluntary sector involvement, institutional services, housing, home and community-based services, service scope, and research.

COORDINATION OF SERVICES

A number of the European nations have recognized the problems in the delivery of long-term care generated by the separation of financing and administration for the two principal components—medical or health services and social services—and some have recently taken steps to remedy the situation. Since 1981, Sweden has established 500 community coordinator positions whose purpose is to foster a closer linkage between the institutional and community-based service elements of long-term care. In addition, several Swedish municipalities have established coordinated centers for social welfare, health, and medical care and have set up area service centers as focal points for arranging and delivering services (The National Commission on Aging, 1982). A major thrust in Dutch public policy for the eighties is the bringing of "coherence" to the planning and reorganization of the services initiated in the 1960's and 1970's (Interministerial Steering Committee on Aging Policy, 1982). In order to bridge the gap between the two public bureaucracies in the local delivery of health and social services in their country, the Norwegian Parliament has been considering legislation that would provide health block grants for health services directly to municipalities rather than to the counties in the same way that the state already provides block grants to the municipalities for the delivery of social services (The Aging in Norway, 1982).

VOLUNTARY SECTOR ROLE

In response largely to shrinking public budgets, at least four of the countries in the study recently have enunciated as public policy in the health and welfare area the encouragement of an expanded role for the voluntary sector, particularly in the provision of long-term care and housing for dependent elders. These countries are the United Kingdom, Canada, Germany, and the Netherlands. The United Kingdom has focused on the neighborhood, as well, as a potential source for bolstering community-based care (Ageing in the United Kingdom, 1982).

EXPANSION OF SERVICES

In response to what they view as gaps in the continuum of long-term care services, most of these countries have launched recent efforts to fill in these gaps. Efforts have been made to expand institutional capacity, housing, and home and community based services.

Institutions

France has undertaken perhaps the most rapid and massive expansion of institutional capacity by using health insurance financing to increase the number of medical care units in public and private nursing homes. In addition, the French plan to use state credits, social security funds, and local community funds to complete a large-scale modernization of older institutions (Secrétariat D'État Chargé Des Personnes Agées, 1982).

Sweden may not be far behind. Starting with 3,000 medical care units in public and private retirement homes and nursing homes in 1980, the Swedes aimed to expand that stock to 22,000 units by the end of 1982. Working through the county councils, which are responsible for medical care in that country, Sweden also has plans to increase the capacity of nursing homes and hospitals for the chronically ill to 54,600 beds by 1986, up from 45,000 beds in 1981. In conjunction with this effort, Sweden plans to move significant numbers of elderly persons out of its psychiatric facilities (The National Commission on Aging, 1982).

Responding to a large-scale transfer of elderly individuals from hospitals to nursing homes in recent years, Germany now has launched not only an expansion of nursing home capacity but also an effort to transform a number of acute care hospitals into geriatric or chronic care units (German Centre of Gerontology, 1982). England, as already mentioned, is proceeding "experimentally" with the expansion of public nursing homes for elderly persons who are not quite impaired enough to require geriatric hospital care. Although Denmark's nursing home capacity is viewed as adequate except in Copenhagen, the Danes are increasing bed capacity as they replace older, private facilities with modern, publicly operated homes. The Dutch are seeking a more widespread geographic distribution of nursing home capacity and have lowered size requirements of individual facilities in order to accomplish that goal (Interministerial Steering Committee on Aging Policy, 1982). In contrast, Canada perceives that it probably has overbuilt its nursing home capacity. As a result, the Canadians are attempting to

turn these facilities into multipurpose settings for the provision of community-based services as well as institutional care (Canadian Governmental Report on Aging, 1982).

An expanded, more versatile function for both existing and new nursing homes seems to be an emerging development elsewhere as well. As in Canada, residential homes in the Netherlands have begun offering day care and meals to elderly community residents (Interministerial Steering Committee on Aging Policy, 1982). Denmark has undertaken plans to raise the number of day care units in existing nursing homes by 30 percent and the number of day nursing homes by 50 percent by 1985 (Erdal, 1982). The United Kingdom, similarly, has recently experienced a significant increase in the number of institutional beds being used for short-stay, day care, respite care and rehabilitation purposes (Ageing in the United Kingdom, 1982). As mentioned earlier, at least three countries—Germany, Denmark, and the Netherlands—are beginning to utilize nursing homes as core units to which sheltered housing can be attached.

Housing

Denmark, in fact, relatively recently began shifting some of the increased funds that had been going for the expansion of nursing home capacity in the late seventies to the construction of sheltered housing (as well as day centers) (Uldall, 1982). Norway recently has begun encouraging the construction of "flatlets" for the elderly as close to local social service centers as possible (The Aging in Norway, 1982).

Home and Community-Based Services

Several interesting developments in the provision of home- and community-based care are taking place as well. Again, countries appear to be filling in existing gaps in what they view as a full or ideal spectrum of alternative service modes. Concurrent with their expansion of nursing home capacity, the French Government is seeking a rapid rise in home health and homemaking services availability (Secrétariat D'État Chargé Des Personnes Agées, 1982). The Netherlands has recently increased the capacity of its family care and family help agencies to provide in-home care to the elderly (Interministerial Steering Committee on Aging, 1982). Sweden began a determined effort in 1980 and 1981 to enlarge its capacity to provide homemaker services and plans to add further capacity through 1986 (The National Commission on Aging, 1982). In sharp contrast, Norway has just imposed a ceiling on the expansion of home help services through the municipalities in response to recession-related budgetary concerns (The Aging in Norway, 1982).

EXPANDED SERVICE SCOPE

The initiatives described to this point constitute, by and large, adjustments to and reallocations within the existing array of standard long-term care services. The number of more innovative measures taken has been relatively few. The Scandinavian countries, it seems, have been the most innovative in extending the scope of

their services. The Norwegians have inaugurated at least one pilot project in Oslo delivering respite care. As well, the Norwegians have set up a number of local day centers to function as focal points for arranging various services for the aged. Norway also is pilot testing the use of rural postmen as extensions of local social service agencies (The Aging in Norway, 1982). Sweden has moved ahead recently to make rural postmen a permanent arm of the local councils, which are responsible for overseeing the delivery of all public social services in that country. There the postmen maintain contact with the rural elderly, arrange social services where needed, and carry out other special service assignments at the request of the local councils. Like Norway, Sweden is reportedly expanding its complement of service areas and day centers. Sweden also is planning a substantial expansion of day hospital capacity—from 4,000 units in 1981 to 5,200 units or beds by 1986 (The National Commission on Aging, 1982). Denmark, as mentioned before, is planning to enlarge its day hospital or day care center capacity by 30 percent and its day nursing home capacity by 50 percent by 1985. The Danes plan to use these facilities as centers for providing physical and occupational therapy as a means of reducing admissions to institutions (Erdal, 1982).

The United Kingdom places considerable emphasis on rehabilitation of the impaired elderly population. In pursuit of this objective the British have set up a number of rehabilitation demonstration centers in hospital departments of geriatric medicine (Ageing in the United Kingdom, 1982). Denmark also is seeking to make rehabilitation available to the disabled elderly. The Danes are mounting a major effort to increase the availability of rehabilitation through their day-care centers (Erdal, 1982).

The United Kingdom has begun to look seriously at expanding primary care utilization among the aged population as a preventive strategy for reducing the need for long-term care (Ageing in the United Kingdom, 1982). Sweden, Germany, and France recently have opted to emphasize the practice of health-promoting activities among the elderly (The National Commission on Aging, 1982; German Centre of Gerontology, 1982; Secrétariat d'État Chargé des Personnes Agées, 1982). These activities, apparently, have been available in the past only through the voluntary sector. Both Sweden and Germany have developed rather extensive traffic safety and exercise programs. Sweden has put considerable resources into the construction of gymnastic facilities for this purpose. Sweden also has developed specialized study circles for the aged population dealing with diet and exercise and has set up a systematic health screening program for the elderly.

RESEARCH

Available information indicates that at least two of the western European countries, as well as Canada, have rather extensive state supported programs of research on the elderly. Canada's is perhaps the most narrowly focused with its emphasis on research and development in the area of electronic technical aids (Canadian Governmental Report on Aging, 1982). The United Kingdom also is gearing some of its R&D for the elderly toward the area of elec-

tronic communications. In addition, the United Kingdom is studying the role that volunteers, informal caregivers, sheltered housing and residential care play or could play in the provision of long-term care. Taking a somewhat longer-range approach, the United Kingdom as well, is placing considerable emphasis upon biomedical research of chronic diseases (Ageing in the United Kingdom, 1982). The Dutch are focusing most of their research efforts on studying the process of aging. To give guidance to their research agenda, they recently have appointed a steering committee on aging research which is to function in that capacity over a full 5-year period (Interministerial Steering Committee on Aging Policy, 1982). In addition to treatment of the aging process, Sweden's research agenda calls for studies of social factors that contribute to health, preventive measures, noninstitutional measures, and methods of involving the elderly and of counteracting social isolation (The National Commission on Aging Policy, 1982).

In virtually all of these countries it is likely that a number of these initiatives have languished in the planning or early implementation phases due to budgetary cutbacks accompanying the recent recession (Nusberg, 1983, 1984). Nonetheless, their mention in this chapter does provide an indication of the direction in which these countries are headed or wish to go with regard to long-term care policies and programs for their dependent elderly populations.

Chapter 5

IMPLICATIONS FOR THE UNITED STATES

The European experience in caring for older populations, perhaps, is instructive more for what it tells us about the inevitable responsibilities accompanying an aging society than about the public policies which can be implemented to reduce those responsibilities. Two factors seem to determine the amount spent on public programs for the elderly. The evidence presented here suggests that total public spending for the elderly in Europe has grown as populations in those countries have grown older. Also total public spending for the elderly appears directly related to GNP per capita, suggesting that the level of public programs for the elderly is related to a country's wealth.

CASH BENEFITS VERSUS SERVICE BENEFITS

The distribution of available public resources for the elderly among the various expenditure categories varies across countries. Germany is reported to emphasize cash benefits rather than service benefits for the elderly (Kahn and Kamerman, 1976). Further study should be undertaken to evaluate the extent to which an income strategy for the elderly is stressed in Germany and, if so, to assess whether German elderly combine these cash benefits with other personal resources to achieve a different standard of living and long-term care than do the elderly in other countries, and to learn whether emphasis on cash is a more or less efficient model of support for the elderly. Comparisons should be made with other countries where public pensions represent a relatively low proportion of total public support for the elderly and in which there is a comparable per capita level of public spending on the elderly.

PUBLIC FINANCING OF HEALTH CARE

Public spending on health care for the elderly as a percent of GNP appears to be especially closely associated with the size of the elderly segment of the population, and it would seem probable that Canada and the United States can expect to spend a greater proportion of GNP in this area in the future. One exception to this pattern can be observed in the United Kingdom, where per elderly public health care expenditures are held down by a cap on total national public health expenditures. This policy, however, may have a detrimental effect on the availability of long-term care in the United Kingdom, which is funded primarily out of the national health budget. There is a reported shortage of both nursing home and geriatric hospital bed capacity in the United Kingdom which, if remedied, could have a significant upward impact on expendi-

tures. Another exception to this pattern is Switzerland, where heavy reliance on private sector financing and a high level of GNP per capita—nearly double that of the United Kingdom—permits reasonable public spending on health care for the elderly even though the proportion of GNP spent is very low.

PRIVATE FINANCING

Greater private sector financing of health care for the elderly in the United States has received increasing attention. Larger copayments and cost sharing by medicare beneficiaries would be somewhat analogous to health care financing in Switzerland where each person is primarily responsible for paying his own insurance for old age and health. It is one option for limiting public health care expenditures for the elderly and, perhaps, reducing unnecessary health care utilization through economic incentives. It is also an option which avoids capping total health care expenditures, a measure which has had little public support in the United States. For these reasons, the experience in Switzerland, where the rate of growth of the proportion of elderly in the population and the proportion of the elderly who are very old are among the highest in Europe, should be examined more closely. Attention should be given to all the resources available to the elderly, public and private, personal and familial, and to the impact on their life situations of larger private involvement in financing health care. An in-depth analysis of the Swiss experience is beyond the scope of this report, however.

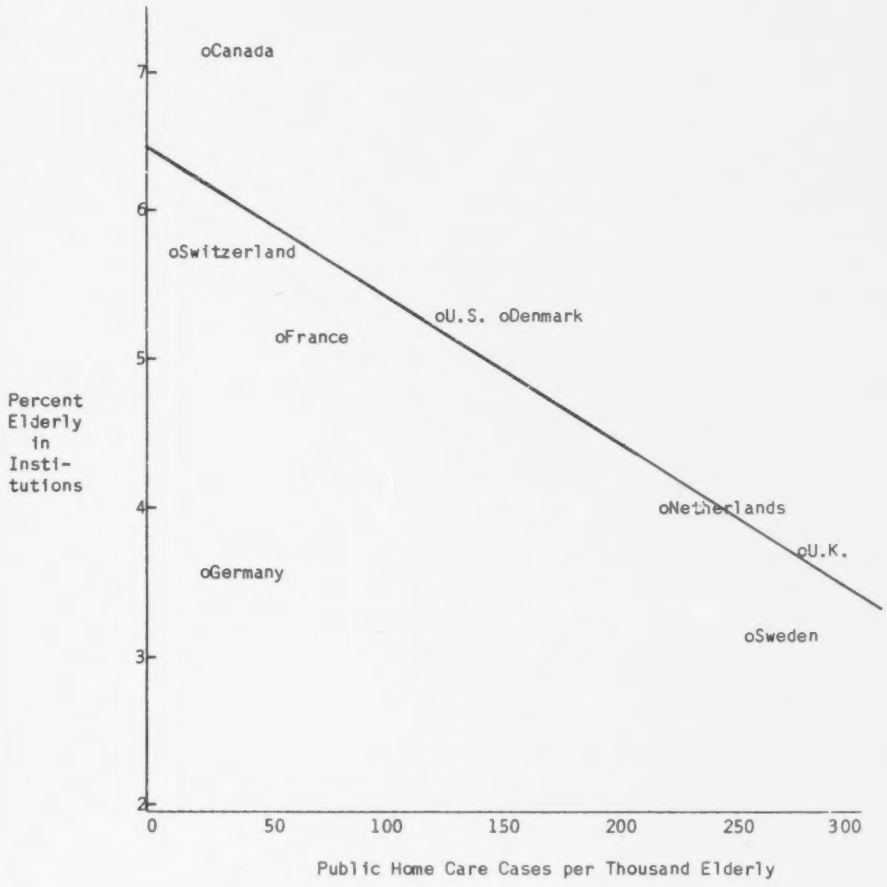
One possible way of limiting public expenditures for institutionalization is to seek private contributions toward room and board expenses, as is the case in France to a limited extent. Given that most nursing home patients already spend considerable amounts of money for their care, however, further significant private spending by most nursing home clients is probably not feasible. Additional revenues may be sought under family responsibility laws, but so far, these do not seem to have worked.

FORMS OF LONG-TERM CARE

Data on spending for long-term care for the elderly are not available. Data have been gathered, however, which provide some insight into utilization of the major forms of long-term care across the 10 countries in the study (tables 7 and 8). Comparisons drawn from these data must be considered tentative, as the consistency of definitions of services across counties is not guaranteed.

In figure 2, institutionalization is compared with the amount of public home care provided per thousand elderly. The figure shows that institutionalization rates are generally lower in countries with higher levels of public home care, and vice versa. The mechanisms behind such differences are unknown. The figure suggests that a possible tradeoff may exist between institutional care and home care.

Figure 2
Relationship Between Percent Persons 65 Years and Older in Institutions and Public Home Care per Thousand Elderly [1]



[1] R^2=.76 (excluding Germany).

Institutionalization rates also are generally lower in countries with higher utilization of group quarters, although the association is weaker than between institutionalization and home care. A possible tradeoff of group quarters for institutional care is suggested.

The data in tables 7 and 8 also indicate that the use of group quarters by the elderly is generally greater in countries with higher levels of publicly provided home care. It is interesting to note that the study countries can be divided into two groups: Those with greater than 5 percent of the elderly living in group quarters (the United Kingdom, the Netherlands, Sweden, and Norway) and with high levels of public home care, and those with less than 2 percent of the elderly living in group quarters (the United States, Canada, France, Germany, and Denmark) and with low to moderate levels of home care. This suggests that large amounts of home care may facilitate or enable habitation in group quarters for many elderly. Thus, a combination of the two alternatives may be required to reduce or maintain lower institutionalization rates.

Several countries in the study exemplify aggressive policy in the direction of alternatives and warrant a closer look. In recent years, the Netherlands has constructed large amounts of congregate housing and sheltered flats as an alternative to institutional settings; France is in the process of initiating a similar program. The United Kingdon has a strong commitment to home care, which includes strong outreach and monitoring components.

At the heart of the issue of alternatives is the problem of targeting: How to assure that care is provided at the lowest appropriate level. Although this problem is at least as much a political as a technical problem and one which, ultimately, will have to make room for considerable assessor discretion, the development of more sensitive assessment instruments could aid in the timely identification of those persons who would face institutionalization in the absence of community care. For example, if the relationship shown in figure 2 were to hold within countries as well as across them, the tradeoff would imply the need for 10 new home care cases for each person not institutionalized. Improved targeting would lessen administrative costs of delivering home care and make it a more attractive alternative.

Most countries studied are indeed focusing on the problem of targeting. Several countries have mandatory standardized screening mechanisms to determine who will be admitted to an institution even in the absence of finely tuned assessment instruments. Some countries have carried their efforts to target services appropriately a step further. They apply standardized screening criteria to all candidates for long-term care services of any sort, not just nursing home care, and they require such assessments of all payers, not just public-pay clients.

ORGANIZATION OF LONG-TERM CARE SERVICES

Looking across the long-term care service organization and delivery spheres of these countries, one is again struck more by the similarities to the U.S. system than the differences. The organization of the various components of long-term care, for example, medical versus the social service element, are remarkably similar, despite

significant differences among the countries in their cultural and political development. With the exception of rather extensive use of geriatric hospitals which are very uncommon in this country, the scope of services available in the study countries closely resembles that in the United States. The problems encountered with their long-term care systems are ones familiar to American policymakers, although several of the countries (Denmark, France, and Germany) perceive a more serious overuse of acute hospitals for care of chronic conditions than is the case in this country.

LONG-TERM CARE REFORMS

The approaches taken to these problems and the solutions advanced are parallel to the U.S. experience. None of the countries in this study is espousing a grand scheme or undertaking a massive movement to revolutionize the manner in which impaired elders are cared for. Their approaches might best be described as tinkering with the existing system or, as it is sometimes referred to in the United States, muddling through. Some emphasis is being placed on modifying the structure of the relationships among the bureaucratic parts of the long-term care system, although much of the effort is directed toward filling out the spectrum or filling in the gaps where services that would make a complete, ideal continuum of need fulfillment are perceived as missing or as inadequately supplied. Even these incremental efforts, however, as in the United States, often have fallen victim to fiscal pressures created by the recent worldwide recession and have been scaled back accordingly. It is the noninstitutional rather than the institutional services which appear to have been affected more adversely by budgetary restraints.

Despite the overall pattern of similarity, there are a number of important differences between the experiences of these countries and that of the United States which are well worth noting. A few of the countries may have progressed farther than the United States in bridging the gap between the health and social services bureaucracies in the coordination of long-term care service delivery. At least, several seem to be doing more experimenting with methods to overcome the coordination problem.

One innovation to improve coordination that appears to be far more widespread in Europe than in America is the neighborhood or catchment area service center. The service center functions as a focal point for arranging and delivering services to the elderly in the community. Perhaps these centers resemble in function our area agencies on aging, or our experimental, long-term care channeling agencies, but they appear far more numerous and more concretely attached to neighborhood areas in the European countries than these entities do here. Unfortunately, no evaluations have been performed which might indicate whether these centers are cost effective or improve the quality and availability of long-term care.

In large part to enhance coordination, several of these nations have delegated more of the responsibility for care delivery to the local level, although delivery mechanisms appear to have been somewhat more decentralized to begin with than is the case in this

country. Certainly the municipalities carry a heavier burden for financing service than cities or even counties typically do in this country. Municipalities in Europe seem to function similarly to our State governments in this respect.

FINANCING

Virtually none of these countries have recently altered their financing arrangements for funding long-term care. It is clear that central governments, as a consequence of their dominant fiscal role and overall statutory authority, set overall policy goals in this area and can readily require the municipalities to comply. True breakthroughs in the coordination of service delivery at the local level seem unlikely so long as the municipalities are dependent on separate sources of funding from the state health, welfare, and housing bureaucracies.

SCOPE OF SERVICES

Although the scope of services available in most of these countries resembles that in the United States, the emphases are different. The differences are particularly notable in the Scandinavian countries. Services that are emphasized and so are more prevalent include day care, congregate housing, rehabilitation, respite (at least in the United Kingdom) and preventive or health promotion services. Also it is quite clear that most of these "alternative" services are more readily accessible—because of more liberal eligibility criteria—in the Scandinavian countries and in the United Kingdom, at least, than they are in this country. The commitment to such services as a way of enhancing the quality of life for the dependent elderly has a longer history there. Even the scope of services is perhaps measurably broader in the Scandinavian countries. Denmark, for instance, will assist elderly individuals with gardening (in part, because gardening is seen as therapeutic and thus preventive) and provides public support for "pensioners' clubs." Finally, there is substantial public support for familial care-givers in Scandinavia, in particular, as well as in England. This issue has arisen as part of the policy debate only very recently in this country.

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APPENDIX

LONG-TERM CARE PROGRAMS

Canada

Responsibility for the public provision of long-term care in Canada lies with the Provincial governments. As a consequence, the availability of services other than institutional care varies significantly by locality. Institutional care is used rather heavily in most Provinces. The private proprietary and voluntary sectors are heavily involved in care delivery as well, usually with Provincial funding. The central government's role is limited largely to assisting the Provinces financially.

Some health services are funded through Provincial hospital and medical care plans. Provided these plans meet centrally established criteria, they may receive a Federal contribution. A significant portion of long-term care services, however, is provided through block funding to the Provinces under the extended health care services program. These services include nursing home and adult residential care, health components of home care, and ambulatory services. Through the Canada Assistance Plans, the Provinces also receive partial reimbursement for the provision of selected institutional services not covered by the block grants.

France

Formal long-term care services in France, relatively undeveloped until very recently, are now undergoing rapid growth—at least those medical components that are included under the country's universal health insurance. France has relied heavily in the past on the use of acute hospitals and psychiatric hospitals for care of the impaired elderly. The costs of such utilization are covered 100 percent by social security funds. Now France also is making an effort to develop its home care and nursing home care capacity simultaneously. The latter is being accomplished with earmarked funds.

In addition to expanding capacity, older nursing homes are being modernized, using a combination of funding sources: state credits, social security funds, and revenues of the municipalities. Nursing homes are offered incentives to develop medical care sections so that less use of hospitals will be needed. Medical care in both their nursing home units and the hospital long-term care units is paid for at a fixed prospective rate by the social security fund, while the other nursing home services—room, board, and shelter—must be paid from some other source.

As well, the French are now developing a system of medium-term service units in their hospitals with which to provide a con-

tinuation of active treatment after the acute phase and to prepare patients for independent living in the community. Medium-term services are covered 100 percent by social security funds.

The state also is encouraging the availability of temporary sheltering residences in varying types of settings for use as transition living quarters for persons recently hospitalized and for use as respite and winter care accommodations. Such services as day hospitals, meals-on-wheels, transportation, and various home helps are being developed.

Germany

Like most Western European countries, the Federal Republic of Germany has virtually the full complement of long-term care services. These appear to exist in shorter supply and with wider variations in availability geographically than is the case in most of the other countries, however. Home nursing and homemaking services, as well as nursing home care (if short term), are funded under the mix of public and private health insurance schemes existing in Germany, provided their services are delivered by credentialed health professionals. The public scheme is financed through a combination of contributions from the social security authorities and taxes on the work force. Most other publicly provided services for impaired elders are funded by local governments through the social welfare system. This includes long-term home nursing and long-term institutional care. No direct support programs for family caregivers have been established.

The bulk of long-term care services is provided by six large private welfare organizations, which receive most of their funding from the government. They operate 55 percent of the institutions and 34 percent of the hospitals as well as major portions of ambulatory and supportive services.

The Netherlands

The responsibility of financing and administering long-term care services in the Netherlands is shared by the central government and the municipalities. All services are covered under the country's national health insurance arrangements which reimburse the localities for the major portion of service costs incurred.

The Netherlands makes relatively heavy use of sheltered housing for impaired elders. Nursing home beds, in general, are reserved for those requiring extensive care and for the more severely impaired. A perceived acute shortage of nursing home beds exists, and the state is attempting to create a better geographic spread of facilities.

Dutch policy toward the growth of residential homes (homes for the aging) is quite different, however. It is attempting to lower the capacity of residential homes from the current level of approximately 9 percent to 7 percent of the elderly population. In pursuit of this goal, the state requires all municipalities to establish selection committtees for the purpose of screening all residential home candidiates to ensure that only those candidates with an urgent need for such care are admitted. A uniform set of admission criteria is administered.

Apparently, as a consequence of the policy of restricting the growth in the size of the residential home population, a range of unregulated facilities (which appear to resemble domiciliary care, sheltered care, and board and care homes in the United States) has sprung up. The new facilities typically are sponsored by voluntary agencies and existing residential homes. Day nursing home care since 1978 has been covered by the national insurance scheme and is provided by 100 of the country's 310 registered nursing homes.

Increasingly, the major portion of formal home help care is provided through the country's 247 family care and family help agencies, while the primary health services are seeking to encourage home care provision by friends, relatives, and voluntary agencies.

Need identification and assessment, service linkage and coordination of services are provided through 453 "single" and 45 "multiple" coordinated care of the aging projects. These projects maintain service and aid centers and provide social counseling. The state reimburses the municipalities for 80 percent of the costs of operating these service coordination projects.

Sweden

Three levels of government share responsibility for the funding of long-term care in Sweden. Central government funding comes under the National Insurance Act and provides partial reimbusement to the counties for providing medical care and partial reimbursement to the municipalities for the organization and delivery of social welfare services. Service provision in Sweden is broad and extensive and almost totally under public auspices. For example, 96 percent of all long-term institutional beds are in regional or local public nursing homes or chronic disease hospitals.

Considerable emphasis is placed on the provision of area service-day centers, sheltered housing and, increasing, day hospital care as a means of keeping the aged out of institutions. In quest of this goal, as well, all candidiates for institutions are screened by multidisciplinary assessment teams. Most localities have developed prevention services for the elderly, designed to increase their years of independence. These preventive programs typically include health screening and gymnastics components.

A number of subsidy programs, including housing adaption grants and loans for renovation, enable elderly persons to remain in their own dwellings. These housing programs are largely the responsibility of the local authorities. Rural postmen are used to extend the arm of the municipal welfare agencies into the hinterlands. Family members of impaired elderly are employed in substantial numbers to expand the cadre of home help aids.

Norway

The responsibility for the funding of long-term care in Norway is shared by the central government and the localities. Virtually all services are locally administered under the jurisdiction of municipal social welfare boards. From the national insurance fund the municipalities are reimbursed for 75 pecent of the costs of home nursing and for 50 percent of home help expenses. Day centers also

are partially covered by the national insurance scheme if they are operated by a health institution.

Until very recently, the county level governments retained responsibility for building and operating all health institutions. They were reimbursed for 50 percent of their expenditures from the national insurance budget. Now, the municipalities are given a block grant from the state to cover the provision of both medical and social services.

Like other Western European countries, Norway possesses the full gamut of long-term care services. Norway, like the other Scandinavian countries, places considerable emphasis upon the operation of comprehensive social service centers and will pay relatives to care for impaired elders. In addition, the provision of long-term care in Norway is predominantly a public enterprise, although municipalities fund voluntary organizations to provide services to a greater degree than in Sweden or Denmark. Like Sweden, Norway makes use of rural postmen to extend local social service delivery into the rural areas.

Similarly, housing is recognized explicitly as a key component of noninstitutionalized long-term care in Norway. Funds are made available for the construction of special flatlets for the elderly, for technological improvements to existing dwellings and for rent and for heating. Housing grants are also provided.

Denmark

Long-term care service configurations in Denmark resemble those of Norway and Sweden, although the decisionmaking of local authorities vis-a-vis the central government appears stronger and the role of the social service sector versus the health sector is clearly stronger.

A wide array of services is available through the municipalities, with partial (usually 50 percent) reimbursement from the central government. Private providers play only a very minor role, as is the case in Sweden. As in the other two Scandinavian countries in this study, increasing emphasis is being placed on the provision of day hospitals and sheltered housing. A number of housing subsidy programs are available as well. All candidates for institutional placement are screened by a multidisciplinary assessment team; this includes candidates for sheltered housing as well as those for nursing homes. Worthy of mention is Denmark's prospective capitation approach to the provision of personal subsidies. Each municipality receives from the state a fixed sum per pensioner with which to grant either one-time or continous subsidies to needy individuals for such expenses as medicine, high rent, and heating.

As in Sweden, significant emphasis is placed on prevention as a means of delaying nursing home admissions. Efforts include the establishment of gymnastics, swimming, and sporting programs and, at least in some locations, the provision of advice and counseling to elderly persons in order to enhance the appropriate use of health care services and to reduce social isolation. The emphasis on retaining physical capacity also finds expression in the establishment of day care centers in over half of the municipalities for the provision of psychotherapy and occupational therapy.

Even heavier use of general acute hospitals for chronic care of the elderly seems to take place here than in the other Scandinavian societies, although very little use is made of geriatric hospitals per se. Geriatric hospitals, it is claimed, would violate the principle of individual privacy—a principle which has led to the closing down over recent years of all homes for the aging and the rapid construction and modernization of nursing homes with private room occupancy only.

Perhaps unique among the countries studied is Denmark's emphasis upon training of all home helpers—an obligatory 304 hours of training. Twenty-four hours of completed training are required before the helper initiates any care-giving.

Switzerland

Swiss sickness insurance is based on the principle of voluntary individual insurance. Federal law, however, empowers the cantons (22 political subdivisions) to declare the insurance compulsory for some or all classes of the population (96 percent of all Swiss are privately insured for hospital costs). It also fixes the minimum benefits to be paid by the private funds. Cantons pay all or part of the premiums for old people if they need assistance; the proportion varies by canton.

Most long-term care (including nursing home care) is purchased with private resources. Nursing home and home care are provided by the cantons for persons with insufficient resources. By Federal law, every community must have an office which counsels and assists old people. Persons who qualify as needing the assistance of others for activities of daily living or supervision may receive a disability allowance from the national old age insurance scheme, which is partly subsidized by the federal government.

United Kingdom

The public provision of long-term care in the United Kingdom comes from two principal sources: The National Health Service, which covers medical or health care components and the social service departments of local authorities, which are responsible for home nursing and all supportive domiciliary services. Generally, service offerings are rich and readily accessible, although some cutbacks in line with national budgetary constraints have been instituted. Heavy emphasis is placed on home care and rehabilitation. At the same time, heavy reliance is placed on care of impaired elders in long-stay units of general hospitals (or units attached to general hospitals) that are part of the National Health Service system.

Private, voluntary organizations also play a large role in care provision in the United Kingdom, including the operation of a large number of residential homes. The central government is encouraging even greater cooperation between local authorities and these private organizations. The British recognize the key importance of appropriate housing and actively encourage sheltered housing through the housing authorities and housing associations, as well as by making it available through municipal home improvement grants for private dwellings.

A series of income allowances are paid to disabled elders and their family care-givers in order to encourage independent living. An attendance allowance and a mobility allowance are made available to persons meeting eligibility criteria for them. An invalid care allowance can be paid to family care-givers of disabled persons.

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